July 20, 1999

Joan Peterson, Ph.D., Project Officer
Health Care Financing Administration
Center for Medicaid and State Operations
Division of Integrated Health Systems
7500 Security Boulevard
Mail Stop C3-18-26
Baltimore, Maryland 21244-1850

Dear Dr. Peterson:

SUBJECT: THREE YEAR WAIVER EXTENSION

The Arizona Health Care Cost Containment System (AHCCCS) is seeking HCFA approval for a three year extension of the Section 1115 Research and Demonstration Waiver beginning October 1, 1999 and ending September 30, 2002. The budget information is being prepared and will be mailed to you within the next few days.

The extension is needed to complete the following initiatives.

QUALITY IMPROVEMENT (QI) INITITATIVE

Since early 1995, the QI Initiative has been a primary focus for AHCCCS. In partnership, AHCCCS and the health plans and program contractors have been using encounter data to measure quality outcomes to improve health care for AHCCCS members. The following are the major components of the Initiative.

Acute Quality Indicators

AHCCCS and the health plans initially defined eleven acute care quality indicators. A year later, two of the indicators, Cesarean Section and Asthma, were deleted and Well Child (3, 4, 5 and 6 Years Old) was added to conform to more recent HEDIS information. In 1996 and 1997, baselines were established for ten of the eleven acute care indicators. AHCCCS is currently working on reports for the 1997/1998 time period, which will be submitted in late 1999. Baselines for the eleventh indicator, Adolescent Well Care, will be developed in 2000.

*Diabetes Management Audit*Diabetes Management Audit

The 1996/97 Medical Audit on the Management of Diabetes provided baseline data for quality improvement plans. In 1998, each health plan conducted a clinical study of diabetic members. The findings of the studies have been analyzed by AHCCCS and shared with the plans. The plans shared the findings of the studies with each other in order to determine best practices and to improve outcomes. By sharing information health plans are finding they can avoid repeating each others mistakes and build upon their accomplishments.

Other Multiple Year Projects

Other multiple year projects include a 1997/1998 Annual Medical Audit of EPSDT services which was submitted to HCFA on July 14, 1999. AHCCCS is also beginning a study of persons who are eligible for both Medicare and Medicaid with the initial effort being to improve influenza immunizations for this vulnerable population by working with their Medicare providers.

*Childhood Immunization Annual Audit*Childhood Immunization Annual Audit

Since 1994, AHCCCS has completed an annual Childhood Immunization Audit, which provides AHCCCS and the health plans with important information on the percentage of children who receive immunizations. The results of these studies show that AHCCCS continues to make significant progress toward meeting the goals for childhood immunizations outlined in the Healthy People 2000 report. The Audit also provides data that is used as a benchmark to determine immunization goals for the health plans. If the health plans have not achieved the statewide average immunization rates by the end of the contract year, the health plan must submit a corrective action plan to AHCCCS.

*Pharmacy Encounters*5Pharmacy Encounters

In October 1997, AHCCCS required the health plans to report pharmacy encounters. AHCCCS reports pharmacy utilization using data reported by the plans and will eventually run these reports from the pharmacy encounter data. This will enable the agency to link pharmacy data to encounter information and do more in-depth reporting, including specific drug classes as they relate to diseases.

HIV/AIDS Studies

Two health plans are participating in a medical record review and claims data review to determine

the best data sources to identify HIV/AIDS members, treatment protocols used and the subsequent outcomes. In the next few months the pilot study will:

Complete additional analysis based on recommendations from HIV/AIDS experts.
Identify pertinent quality indicators in the care and management of HIV/AIDS members.
Develop another study incorporating the refined indicators.

ALTCS Quality Indicators

AHCCCS and program contractors defined six quality indicators for ALTCS. Reports for five of the six indicators will be submitted to HCFA in the later part of 1999. The remaining indicator, Psychotherapeutic Agents has been put on hold for review in 2001

AHCCCS and the Department of Economic Security/Division of Developmental Disabilities (DES/DDD) defined six indicators for the ALTCS members who are developmentally disabled. Initial reports were submitted to HCFA for DD Health/Safety in Group Homes and DD Program Monitoring in Group Homes. Since the fall of 1997, DES/DDD has been participating in the pilot for the National Core Indicators Project in lieu of the AHCCCS QI Project.

Utilization Reports

Various enhancements to the utilization reports are planned to assist with trend analysis for outcome data. The Encounter Project identified the most common procedures billed over specified daily limits. Each procedure was analyzed to determine if the limit was outdated or if there was a coding error in the submission of the encounter. As a result, unit maximum limits were updated in the reference table for over 100 procedures. Phase II of the project will identify the most common procedures billed over the daily limits for laboratory, radiology, nursing facility, home and community-based services and therapy services.

Physician and other practitioner reports are being enhanced to add age breakdowns, which will help us in monitoring under and over-utilization of the physician and practitioner services. Sub-categories will be added to the reports submitted in 2000 and age breakdowns will be provided in the 2001 reports.

The Maternity Services report is being modified to distinguish between normal deliveries, operative deliveries and length of stay outliers. These changes are expected to be included in the Maternity Services reporting for May 2000.

The development of a utilization management oversight process will be completed by June 2002. The project will review utilization management of acute care services by the health plans and program contractors. The focus will be on the health plans and program contractors to ensure that they have an adequate oversight process to avoid under or over-utilization of services by the provider community.

*Financial Indicators*Financial Indicators

AHCCCS and the health plans developed four financial indicators to evaluate the financial performance of the health plans. The first report on the financial indicators was submitted in 1998 and the second report, based on 1998 audited data was submitted June 5, 1999. The financial indicators help AHCCCS determine:

If the health plan can remain fiscally viable given current capitation rates.
How well a health plan manages care.
If claims are being paid timely.
How well a health plan is recording medical expenses.

Member Satisfaction Surveys

In 1996, AHCCCS conducted a member satisfaction survey of acute care members. The purpose of this survey was to provide a baseline for measuring quality improvement. AHCCCS will begin development of a second acute care member survey at the beginning of 2000. From January 2000 through the fall of 2000, AHCCCS will seek input from stakeholders, select a survey instrument and identify Arizona specific questions for the survey. During the same period, AHCCCS will conduct focus groups, refine the tool, and select sample criteria. Fieldwork will begin during the last quarter of 2000 with the final report due in the fall of 2001. The results of the second member survey will be compared to the baseline survey to measure quality improvement and identify areas of opportunity for further improvement.

In the summer of 2001, AHCCCS will identify potential funding sources, apply for grants and begin development of the ALTCS member survey. Fieldwork for the ALTCS survey is scheduled for the summer of 2002 with the final report due by the end of 2002. The results of the ALTCS member survey will be used to compare program contractor performance, measure member satisfaction and identify opportunities for improvement.

Provider Survey

In 1998, AHCCCS conducted the first phase of the Provider Survey by surveying physicians and office managers in primary care and specialty practices. The survey covered a broad range of topics including: the contracting process, reimbursement, policies and procedures, utilization management, provider education and communication, quality management and claims payment. AHCCCS will use the survey information in contracting and oversight activities and as a baseline component of the Quality Improvement Initiative. AHCCCS will begin working on a dental survey of providers this summer.

In the spring of 2002 the ALTCS program will begin seeking grant funding and begin developing the ALTCS' provider satisfaction survey. Fieldwork is scheduled for the first quarter of 2003 with the final report to be completed by the end of that same year.

AHCCCS plans to continue to administer future acute care and ALTCS surveys, which will be used as data sources for the QI Initiative.

UNIVERSAL APPLICATION

AHCCCS is developing a universal application that will be used for all AHCCCS programs. Initially, the application will be used for the following programs:

Arizona Long Term Care System
Medicare Cost Sharing programs
SSI-related for the elderly, blind, and disabled
Children's Health Insurance Program (KidsCare)
Premium Sharing Demonstration Pilot

AHCCCS will coordinate the use of the universal application with DES for families with children, federal poverty level children and pregnant women. The universal application will not be used to determine eligibility for TANF or food stamps. Additional information needed for a specific program will be obtained through supplements to the application such as a Resource Supplement, Medical Expenses Supplement or Prior Quarter Supplement.

AHCCCS plans to establish a one-stop shopping intake unit to be located in Central Office. An AHCCCS Program hotline will be available and applications will be screened to determine the programs for which the client may be eligible. This unit will refer the completed application to the correct eligibility agency/unit and provide the client with instructions on how to proceed. AHCCCS will develop an informational brochure that will explain the various AHCCCS programs and general

eligibility requirements for each. This brochure will be provided with the universal application.

COMPETITIVE BIDS AND CHOICE OF ALTCS CONTRACTORS

By October 1, 2000, AHCCCS will solicit competitive bids on a statewide basis for the ALTCS program. Until recently, Arizona law mandated that Maricopa and Pima Counties be the program contractors for their respective counties. The open bid process will test the principles of competitive bidding and competition on a statewide basis. Equally important, AHCCCS will develop geographic service areas and award contracts to more than one respondent in the two urban areas, which will provide ALTCS members, a choice of plans.

HAWAII/ARIZONA PARTNERSHIP **HAWAII/ARIZONA PARTNERSHIP**

In August 1994, the Med-QUEST Division (MQD) of the Hawaii Department of Human Services implemented an 1115 managed care program named the QUEST program. Under the terms and conditions of their waiver, MQD is required to collect, process and report key data about the program to HCFA and to have an information system in place to support the management of the QUEST program.

In 1994, MQD contracted with a vendor to design and implement a comprehensive, fully integrated data processing system to support QUEST. The system was not delivered and MQD terminated the contract. After considering various alternatives, Hawaii approached Arizona to suggest exploring a partnership with AHCCCS that would enable Hawaii to share Arizona's certified Pre-paid Medical Management Information System (PMMIS). An AHCCCS/QUEST partnership will enable both states to pool resources and share the costs of running the current system and of future enhancements. In addition to the benefits for Hawaii, the prospect of a partnership between the two programs will provide the following benefits:

Lower development costs for Hawaii and HCFA.
Lower operating costs in the future.
Enhanced FFP for future projects benefiting both Arizona and Hawaii.
An opportunity to implement a new program that would attract and retain information technology employees.
Joint development of future innovative and cost effective systems in the health care field.

Although there are issues that must be resolved, Hawaii and Arizona are highly motivated to reach agreement on this project.

REQUEST FOR NEW WAIVERS AND CONTINUATION OF EXISTING WAIVERS AND EXPENDITURE AUTHORITY

AHCCCS requests approval of all currently authorized waivers and the expenditure authority contained in the 1998 approval letter. AHCCCS has many outstanding waiver requests as identified in Attachment A. Considering that some of these requests have been awaiting approval for over three years, AHCCCS requests approval of these outstanding waivers and the new waivers discussed below.

EXPANSION OF THE WAIVER TO USE THE PAS FOR DISABILITY DETERMINATIONS

In order to be eligible for Medicaid, persons 64 years and younger who are applying for SSI must be disabled. Disability determinations are conducted by the DES/Disability Determination Services Administration (DDSA). The determination evaluates an individual's ability to return to the workforce in the next 12 months.

The cost of the disability determinations is approximately $200,000 per year for ALTCS members. AHCCCS believes that there is a much more efficient way to determine whether an individual is disabled for the purpose of receiving long term care services under Medicaid. AHCCCS is requesting HCFA permission to build on the current waiver which authorizes us to determine disability for children under the age of 18 using the pre-admission screening (PAS) tool. By adding adults to the waiver, AHCCCS can demonstrate that using the PAS tool is less expensive, more timely and provides improved customer service by getting eligible persons into managed long term care more quickly.

Currently, AHCCCS conducts a pre-admission screening (PAS) for every ALTCS client to determine if the individual is risk of institutionalization and eligible for long term care services. The current process requires a second, duplicative disability determination by the DDSA after AHCCCS has determined the person is at risk of being in an institution. Moreover, this second disability determination by DDSA generally requires a minimum of 45 days to be completed. While we wait for this second determination, the disabled individual is unable to receive needed services through Medicaid.

An initial review of DDSA determinations indicated that about 5% of persons who pass the PAS subsequently fail the DDSA disability determination. This is troublesome since these individuals generally are extremely ill and the reason they fail the DDSA determination is because DDSA cannot determine if the person will recover within 12 months and return to the workforce. This is a convoluted denial reason and a process that needs to be improved. Using the PAS will solve these limited situations and make eligibility determinations much timelier. Appendix B provides a detailed explanation of the proposal.

CAP ON HOME AND COMMUNITY BASED SERVICES

The current cap of 50% for the elderly and physically disabled population is too restrictive to meet the demand for home and community-based placements anticipated to be needed between October 1999 and September 2002. HCFA's independent evaluator, Laguna, has published data showing that ALTCS is cost-effective and that alternative placements are critical to the success of the program. Last year, as required by HCFA, Bill Weissert, Ph.D. completed a follow-up study on the Laguna cost-effectiveness of HCBS in ALTCS and concluded that "…the study did not find evidence to support the assumption of a woodwork effect large enough to offset savings from substitutions of HCBS for nursing facility care." Dr. Weissert added that, "Relaxation of caps on HCB services has not compromised cost-effectiveness." Equally as important, Laguna Research concluded that the AHCCCS' preadmission screening tool is state-of-the-art and effectively limits admission to ALTCS to those who are in need of institutional care.

To avoid the woodwork problems other states have encountered, AHCCCS developed a strict medical eligibility criteria to ensure that only those who are in need of long term care services are enrolled in the ALTCS program. The ALTCS program works the way it was intended and AHCCCS requests that the cap be removed entirely. If HCFA chooses not to remove the HCBS cap, AHCCCS requests an increase of the cap from 50% to 60%. This 10% increase should provide sufficient capacity for home and community-based placements and growth through September 2002. The historical growth in HCBS services which is:

HISTORICAL HCBS PERCENTAGES

MONTH/YEAR	PERCENTAGE
September 1989	7
September 1990	14
September 1991	17
September 1992	16
September 1993	26

September 1994	30
September 1995	33
September 1996	36*
September 1997	38.8*
September 1998	41.8*
May 1999	43.9*
* These percentages include Native Americans.	

The following provides additional support for this request:

Between September 1998 and May 1999, the percentage of ALTCS members in home and community based settings increased 2.1 percentage points. Based on an average monthly increase of .23% per month, a reasonable estimate of the annual increase in the HCBS percentage from June 1999 through September 2002 is 9.2 percent. With continuation of this growth rate we will reach the current 50% cap well before the end three year extension period.

The utilization of alternative residential settings continues to be an important aspect of the HCBS options for ALTCS members. These settings are highly desired by ALTCS members who do not have the necessary home supports or for whom it is not cost effective to remain in their "own home". The three primary settings used for non-behavioral health are Adult Foster Care , Assisted Living Homes (formerly Adult Care Homes) and Assisted Living Centers - Units formerly Supportive Residential Living Centers. Behavioral health alternative residential settings are also available.

On October 1, 1999, AHCCCS will begin a legislatively approved three-year pilot demonstration of Alzheimer's Assistive Living facilities. This demonstration may include up to 50 ALTCS members during the first year and up to 100 members in the third year. During the final year of the pilot, AHCCCS is required to submit a report to the legislature stating whether the facilities should be approved as permanent alternative settings for ALTCS members. If this demonstration is as successful as previous alternative setting demonstrations, AHCCCS will have another setting where members can receive HCBS and one which meets the specialized needs of members with Alzheimer's disease.

At the end of the 1997 fiscal year, 742 members, or 11.9% of HCBS members, resided in alternative residential settings. As of May 1999 there were a total of 1,015 or 14.9% of HCBS members residing in alternative residential settings.

AHCCCS has reimbursement incentives for program contractors who exceed the assumed HCBS

percentage. In fact, some program contractors have set strategic goals of 45% to 55% for HCBS placements. Under the reimbursement incentive program, the program contractor is rewarded for achieving a higher percentage of home and community-based placements. AHCCCS allows program contractors to retain 70% to 80% of savings, which are calculated as the difference between an institutional rate and the HCBS rate. For example, if the assumed HCBS percentage was 40% and the contractor achieved 45% for a certain number of members, the program contractor would be allowed to keep 70% to 80% of the difference between the institutional rate and the HCBS rate for the number of members involved.

Additionally, AHCCCS shares the loss if the program contractor is unable to meet the targeted HCBS percentage. In this case, AHCCCS will reimburse the program contractor 20% to 30% of the additional cost of providing institutional services to those members who are between the targeted HCBS percentage and the actual percentage. If the assumed HCBS percentage were 40% but the contractor only achieved 37% for a certain number of members, AHCCCS will pay 20% to 30% of the difference between the HCBS rate and the institutional rate for the impacted members.

COST-SHARING CLARIFICATIONCOST-SHARING CLARIFICATION

The Balanced Budget Act of 1997 made it possible for states to impose cost-sharing in a managed care setting without obtaining a waiver. Despite the change in the law, HCFA has approved the AHCCCS waiver to §1902(a)(14) that allows our managed care Medicaid program to charge co-payments. AHCCCS wants to clarify that the following services are excluded from co-payments:

Prenatal care, including all obstetrical visits.
Well-baby, EPSDT care.
Care in nursing facilities and intermediate care facilities for the mentally retarded.
Visits scheduled by a primary care physician or practitioner, not at the request of a member.
Family planning services.
Drugs and medications.

Please contact Lynn Dunton at (602) 417-4447 if you have any questions about this waiver extension.

Sincerely

Phyllis Biedess
Director

C: Ron Reepen

S:\OPC\LRD\2000 Waiver\2000Waiver draft.doc

APPENDIX A*APPENDIX A*

PENDING WAIVERSPENDING WAIVERS

NATIVE AMERICAN DEMONSTRATION WAIVER Allow AHCCCS, in cooperation with the Indian Health Services/tribes, to operate a managed care pilot on-reservation.	Submitted 5/10/94
100% FPL WAIVER Expand eligibility to allow persons with up to 100% FPL to be eligible for Medicaid.	Submitted 5/29/96
ELIGIBILITY SIMPLIFICATION WAIVERS Submitted to HCFA on July 26, 1996. The purpose is to simplify the eligibility process, reduce needless delays in eligibility determinations and improve access to needed services in a more timely manner. The waivers requested are as follows: Standardization of Income Treatment (ALTCS only) - To simplify the income eligibility determination process by treating income the same for all income calculations. Elimination of 30-day Wait for Use of 300% of SSI Income Limit (ALTCS only) - To allow use of a higher income eligibility limit (300% of Federal Benefit Rate) when an individual has passed the Preadmission screening (PAS). Disregard Income and Resources of Spouses and Parents in the Month of Separation (ALTCS only) - The income and resources of responsible relatives (the parent of a child or the individual's spouse) would not be considered in the month an individual ceases to live with the responsible relative. Exclusion of In-kind Support and Maintenance (ISM) as Income (all eligibility groups) To disregard items of food, clothing and shelter received as ISM in the income eligibility determination process for ALTCS, QMB, SLMB, and SSI-MAO.	Submitted 7/26/96
INCOME ELIGIBILITY CALCULATION WAIVER Use less restrictive and more equitable methodology in income eligibility determinations when the applicant/recipient has an eligible or ineligible spouse. Also allows for allocation for children in more equitable manner when child is a minor.	Submitted 7/26/96
MEQC WAIVER Allow AHCCCS to make the Medicaid Eligibility Quality Control pilot a permanent program and continue to target specific problem areas rather than conducting random samples.	Submitted 11/1/96
RESOURCE SIMPLIFICATION WAIVER 1 Companion to Eligibility Simplification Waiver, simplify the resource eligibility determination for Pickles, DWWs, and DACs by applying a simpler life insurance and burial funds calculation and disregarding the value of household goods and personal effects, and mineral, oil and timber rights.	Submitted 12/18/96
RESOURCE SIMPLIFICATION WAIVER 2 Allow resource determinations to be made based on resource verifications produced from any date during a calendar month, making the individual resource eligible for the entire month.	Submitted 6/23/98
IMD WAIVER Expenditure authority to provide behavioral health services in Institutions for Mental Diseases for Medicaid eligible persons 21 through 64 years of age. This waiver is also included as a proposal in the 100% FPL Waiver.	Submitted 8/7/97

APPENDIX B

Request to Expand the Waiver Allowing Substitution of the PAS for Determination of DisabilityRequest to Expand the Waiver Allowing Substitution of the PAS for Determination of Disability

BackgroundBACKGROUND

In July 1995 HCFA approved a waiver allowing the Arizona Long Term Care System (ALTCS) to substitute the Pre-Admission Screening (PAS) for the Social Security Administration's disability determination for SSI eligible children under age 18. A child who is determined disabled under the SSI criteria must still pass the PAS in order to be eligible for ALTCS. The current waiver is based on the premise that since the PAS is more restrictive than SSI disability criteria it can be used to meet the verification of disability required for an individual to be eligibile for ALTCS without requiring an additional disability determination using SSI criteria. AHCCCS is requesting an expansion of the waiver to use the PAS in lieu of the SSI disability determination for all ALTCS applicants and recipients under age 65. Approval of this request would eliminate a duplicative medical evaluation process, reduce application processing time, eliminate costs associated with SSA's disability determination and provide essential services to applicants more expediently.

The DES Disability Determination Services Administration (DDSA) is the State agency responsible for making the SSI disability determination for AHCCCS for individuals between the ages of 18 and 65 and for the Social Security Administration for all individuals under age 65. A DDSA referral is made for less than 3% of the ALTCS applications received.

DDSA referrals were analyzed for the period 7/1/96 through 12/31/99. AHCCCS made 1,811 referrals to DDSA for disability determinations during this period, 1,427 for ALTCS applications and 384 for SSI Medical Assistance Only (MAO) related acute care eligibility determinations. Approximately 79% of the DDSA referrals made by the AHCCCS Administration are for ALTCS applications. The other 21% of the AHCCCS DDSA referrals are to establish disability for individuals applying for SSI-MAO and would not be affected by this waiver proposal. AHCCCS would continue requiring a DDSA determination of disability for individuals who apply for SSI-related acute care benefits because a PAS assessment is not part of the acute care eligibility determination.

Pre-Admission Screening (PAS)

The Pre-Admission Screening (PAS) process includes a face-to-face interview with the client, caregivers, family and anyone else who is familiar with the client's functional and medical needs. The PAS is conducted by a registered nurse or a social worker with professional experience, who attends training classes on how to conduct the PAS as well as ongoing in-service education. The assessor gathers information and reviews medical records from physicians, hospitals, nursing facilities or other providers who know the client. After compiling all the information from the face-to-face interview and medical providers, the assessor completes the functional and medical PAS tool.

There are four age-specific PAS tools for assessing the developmentally disabled (DD) population; 0-2 (up

to the third birthday); 3-5 (up to the 6th birthday); 6-11 (up to the 12th birthday) and 12 and over. There is also an Elderly/Physically Disabled (EPD) tool that is used to assess that population age 6 years old and over. A child under 6 who is not determined to be developmentally disabled, would be assessed with the age appropriate DD tool.

The PAS tools assess whether an individual is at risk of institutionalization and functional status in terms of development, motor/independent living skills/activities of daily living, communication/cognitive, and behavior. The medical section of the PAS assesses medical conditions, services and treatments, medical stability, sensory functions and physical measurements. If the individual does not meet the eligibility threshold by score, the assessor can request that a physician review be conducted.

The PAS requirement for ALTCS eligibility mandates that the individual require the level of care that is provided in a nursing facility. This means the individual has a combination of the following needs or impairments:

requires assistance with activities of daily living, such as bathing, dressing, toileting and eating;
has impaired cognitive functioning;
has impaired continence of bowel and/or bladder;
has psychosocial deficits;
requires nursing care by or under the supervision of a nurse;
requires regular medical monitoring.

An individual who meets the PAS requirements must be unable to care for his or her daily living functions and must require skilled medical monitoring and thus is at a higher level of care than someone who is determined disabled by DDSA.

ALTCS annually reassesses each member's medical eligibility, but reassessment is completed more frequently when warranted. At the reassessment, AHCCCS determines if the individual has improved to the point where the individual is no longer at risk of institutionalization. If improvement is to the degree that the individual requires only supervisory care or less, the individual is determined ineligible for ALTCS.

Cases which require review by one of the ALTCS physician consultants to determine medical (PAS) eligibility, are occasionally determined to need a reassessment in six months if the physician thinks they may improve within that time and no longer be at risk of institutionalization. The ALTCS program contractors are also required to request that AHCCCS conduct a reassessment on an individual they think may no longer be eligible. Program Contractor case management staff see the individual every 3-6 months, so if there were improvement to the point of no longer requiring the level of care that ALTCS provides, the Program Contractor would request that a PAS reassessment be completed.

DDSA Referral and Disability Determination ProcessDDSA Referral and Disability Determination Process

ALTCS applications for individuals between the ages of 18 and 65 are screened immediately after they are received to determine if disability has already been established. Using the Wire Third-Party Query (WTPY) interface with the Social Security Administration, AHCCCS identifies applicants who do not require a disability determination because they are receiving SSI Disability or Social Security Disability

benefits. If the WTPY shows that benefits have been terminated or suspended within the last 12 months for a reason other than no longer disabled, the AHCCCS DDSA Coordinator contacts DDSA to obtain the medical diary end date. A referral to DDSA is not needed if the diary end date is more than six months from the current date. If it is less than six months, a DDSA referral is completed.

When an application that requires a disability determination is identified, the six-page Disability Report required by DDSA and the medical release forms are sent to the applicant for completion prior to the application interview. During the application interview, the AHCCCS eligibility interviewer explains the disability determination process to the applicant and reviews the forms to assure they are correct and complete. Frequently, the applicant asks the eligibility interviewer to provide assistance in completing the form. If additional information or documentation is needed, the applicant is given an additional 10 days to provide it.

Once all information is obtained from the applicant, the eligibility interviewer assembles a referral packet that minimally includes an AHCCCS tracking form, a Disability Determination and Transmittal required by DDSA, the Disability Report, WTPY, and Medical Release forms signed by the applicant or the applicant's legal guardian. Several additional forms may be required depending upon the applicant's circumstances.

The eligibility interviewer's supervisor usually reviews the referral before it is forwarded to the DDSA Coordinator at the AHCCCS Administration office. To expedite referrals, AHCCCS and DDSA have assigned a single individual in each agency who is responsible for handling disability determinations for AHCCCS. These two individuals handle all communications regarding pending referrals. The AHCCCS DDSA coordinator reviews the referral, enters it in the agency's tracking system, and mails the referral packet to DDSA. Once the packet is received by DDSA, the medical records are requested from the providers listed on the Disability Report. In some cases the applicant is required to see a physician for an examination.

While the disability determination is pending, the PAS assessment is completed. When the applicant fails to meet the PAS requirements prior to a disability determination, the DDSA referral is recalled to minimize DDSA referral expenses. Of the 1,427 ALTCS referrals during the period 7/1/96 through 12/31/98, a disability determination was completed by DDSA for 1,183 individuals. The other 232 referrals were recalled by AHCCCS prior to a DDSA decision. Referrals were recalled for a variety of reasons, including the applicant's failure to meet PAS (medical) or financial eligibility requirements, and voluntary withdrawal of the ALTCS application.

Comparison of DDSA Disability Determinations and PAS Assessments*Comparison of DDSA Disability Determinations and PAS Assessments*

The purposes and methodologies of the DDSA disability determination and the PAS medical assessment are significantly different. The DDSA disability determination is primarily used to determine if an individual qualifies for cash payments (SSI or Social Security Disability). The need for Medicare and Medicaid eligibility is secondary to the individual's need for income due to an inability to work. The duration of the individual's disabling medical condition is a primary factor in the DDSA disability determination. Unless the impairment is expected to result in death, it must have lasted or be expected to last for a continuous period of at least 12 months. Prohibiting government supplementation of income for periods of temporary incapacity is logical. It deters government dependency and encourages individuals to

return work. However, the current reliance on the DDSA decision to determine disability restricts a financially limited individual's access and ability to pay for medical services. This situation is counterproductive to medical improvement and recovery. Individuals applying for ALTCS benefits as the result of an accident or acute medical episode have not established a history of impairment for 12 months prior to application, yet may have gravely disabling conditions. A DDSA determination that a person is not disabled is often based on an expectation that the individual's condition will improve to the extent that they will be able to resume employment within 12 months

The AHCCCS PAS evaluation uses more stringent criteria to establish medical need. 14% of the ALTCS applicants determined disabled by a DDSA referral during the period 7/1/97 through 6/30/98 were subsequently determined ineligible for ALTCS based on their failure to meet the PAS medical criteria. ALTCS is also more aware of fluctuations in an individual's medical condition. In most cases, DDSA sets a diary date for reassessment of the individuals disability status several years after the initial determination. ALTCS sees members much more frequently and has the additional oversight of the case management system to identify individuals who may have significantly improved.

The individuals who are denied DDSA but who also pass the PAS are most often severely impaired. Some common cases we see determined "not disabled" by DDSA are; individuals with traumatic brain injuries requiring significant skilled nursing services; individuals who suffered a cerebrovascular accident and are still receiving intensive therapies; individuals who have had serious complications after surgery, and are requiring functional assistance and skilled nursing care. Many of these individuals are in nursing facilities receiving skilled care.

Disability Determinations Completed by DDSA
7/1/96 through 12/31/98

Total Completed
1,427

Determined Disabled
1,082 (91%)

Determined Not Disabled
101 (9%)

PAS Completed
86

PAS Not Completed
15

PAS Eligible
50

PAS Ineligible
36

Please not that 91% of the disability determinations completed by DDSA for the period 7/1/96 through 12/31/98 were approvals. We examined the PAS status of the 9% (101 cases) determined not disabled and found that 37 of these individuals also failed the PAS. PAS assessments were not completed for 15 individuals, and 50 individuals were medically eligible for ALTCS based on our PAS assessment, but were denied ALTCS benefits because they were determined not disabled by DDSA. We further evaluated the 30 individuals determined not disabled by DDSA during the period 5/97 through 12/98, that were

medically eligible for ALTCS based on the PAS assessment. They are summarized as follows:

Placement when the PAS was completed:

16 people were in a Nursing Facility;
13 people were at home or the home of relatives;
1 person was hospitalized.

Diagnoses:

13 people had sustained serious injuries in a motor vehicle accident with 8 of these having head trauma;
3 people sustained other trauma such as burns over 51% of the body or assault;
1 person had a cerebral vascular accident;
2 people had Guillian-Barre syndrome;
11 people had various other diagnoses ranging from subcortical dementia to necrotizing fascitis (1 had acute illness of congestive heart failure and pulmonary edema, but had been sick so long that he had developed severe bilateral foot drop, required physical therapy, and was essentially relearning how to walk).

Services:

14 people were receiving skilled nursing services (ranging from wound care to tracheostomy care and tube feedings) and therapies;
3 people were receiving skilled nursing services only;
10 people were receiving only therapies (physical, occupational, speech) or rehabilitative/restorative nursing, such as restorative ambulation; and
3 people were receiving drug regulation and/or drug administration only.

It is clear that a primary reason for the denial of DDSA is not the severity of the individual's condition, but rather the length of time the person has been impaired or is expected to be impaired. In the Explanation of Determination provided by DDSA, the expectation that the impairment would not prevent employment for 12 months was cited for each individual. Denial of long term care services at this critical point in an individual's recovery can cause further loss of function or lack of improvement. A recent stroke victim or individual with a traumatic brain injury could experience lasting negative effects from a delay of physical, occupational or speech therapies. Many of the individuals who were denied DDSA and therefore long term care, had a significant need for continuing therapies. This could result in higher costs for care which may not provide improvement as quickly or as completely as might have been possible with an earlier intervention.

The PAS eligible individual would not be able to work in any capacity at the time medical eligibility is determined. In contrast, the DDSA determination establishes that an individual cannot work for at least 12 months, which does not necessarily mean the person requires any care for functional or medical needs. In fact many individuals who are currently receiving SSI Disability or Social Security Disability or are determined disabled through a DDSA referral do not pass the PAS. The PAS requirement for eligibility mandates that the individual requires a level of care that is provided in a nursing facility. The individual who is medically eligible for ALTCS is thus at a higher level of care than someone who is determined disabled by DDSA.

AHCCCS currently has procedures in place to closely monitor improvements in the member's condition and adjust ALTCS eligibility accordingly. The ALTCS member's medical and functional condition is monitored throughout the year by a case manager responsible for assuring that the individual receives appropriate long term care services. In addition, ALTCS routinely reassesses a member's medical eligibility annually. In contrast, a DDSA continued disability reassessment is typically scheduled for seven years after the initial disability approval and the individual's condition is not monitored during the interim.

Duplication of Effort*Duplication of Effort*

In accordance with 42 CFR 435.608, AHCCCS requires ALTCS applicants between the ages of 18 and 65 to apply for potential benefits through the Social Security Administration as a condition for ALTCS eligibility. Because the Social Security Administration (SSA) also relies on DDSA to establish disability, the AHCCCS referral to DDSA duplicates the SSA referral. The applicant may be asked to complete identical forms and provide the same medical information to both agencies.

All ALTCS members must be determined medically eligible and in need of the level of care provided in a nursing facility by the PAS. When an individual has been determined disabled to the extent that an institutional level of care is needed, it is redundant to also require a DDSA determination of disability.

If this waiver request is approved, AHCCCS would still require a disabled adult applicant to pursue an application for Social Security benefits as a condition of eligibility, but the determination of the individual's medical eligibility for income benefits would not impede the AHCCCS determination of eligibility for long term care medical benefits.

Administrative Costs*Administrative Costs*

Administrative costs involved in the DDSA disability determination process include:
staffing costs required for training DDSA referral policy and procedures,
maintaining and revising ALTCS policy manual instructions,
completing forms,
gathering documentation,
assembling and reviewing the referral packet,
referral tracking
a fee paid to DDSA for each disability determination.

Approximately 2.5 hours of DDSA referral training is provided during each Advanced Skills training class. Eight classes are presented each year resulting in 20 classroom hours of DDSA training each year. Trainers devote additional time developing and updating instructional materials for the classes.

Interview time devoted to explaining the purpose and procedure of the DDSA referral requires about 10 minutes. An additional 30 minutes is typically needed to help the applicant complete the forms. Assembling the documentation and preparing the referral packet generally requires another 30 minutes per referral. Supervisory review typically requires another 10 minutes. Thus AHCCCS local office personnel typically spend an average of 80 minutes (1.33 hours) per application developing and reviewing each referral before sending the referral packet to DDSA. Approximately 570 referrals are prepared each year requiring a total of 758 staff hours. In addition, one full time employee in AHCCCS administration

devotes approximately 75% of her time to reviewing mailing, tracking and expediting DDSA referrals.

The AHCCCS budget appropriation for FY 1999 for DDSA disability determinations is $208,000. DDSA completes an average of 473 disability determinations for ALTCS applicants each year and the current average cost to the agency is $354 per determination. Therefore, implementation of this waiver would provide a minimum annual cost savings to the agency of over $167,000, and would eliminate all related administrative costs. Using the PAS to establish disability would not increase ALTCS processing costs because a PAS assessment is currently required for all ALTCS approvals.

Processing Time*Processing Time*

Currently, the time frame for processing an ALTCS application that requires a disability determination is 90 days, double the time allocated for all applications that do not require a disability determination. AHCCCS has implemented policy and procedures to expedite internal processing of DDSA referrals. Applications requiring a DDSA determination are identified early in the ALTCS application process and required forms are given to the applicant prior to the application interview. During the application interview, the Eligibility Interviewer reviews the forms, provides assistance with their completion when requested, and asks the applicant to provide missing information within 10 days. AHCCCS frequently receives the medical release forms signed by someone other than the applicant or the applicant's legal guardian. New medical release forms must be sent for the applicant's signature that delays preparation of the referral. The referral is reviewed by local office staff and then by the DDSA Coordinator to assure that DDSA's determination process is not delayed due to incomplete or missing documentation. The referral typically does not reach DDSA until 15 to 30 days after the ALTCS application date.

AHCCCS and DDSA staff have an excellent relationship and have worked together to streamline the disability determination process as much as possible. AHCCCS assumes responsibility for gathering most of the preliminary information required by DDSA: the Disability Report and Vocational Report, verification of the applicant's current Social Security status and medical release forms signed by the applicant that enable DDSA to request copies of medical records from medical providers. AHCCCS also provides personal assistance to applicants who need assistance completing the forms. Through a mutual agreement to facilitate communication and processing of the referrals, responsibility for tracking and processing referrals is assigned to a single individual within each agency. AHCCCS and DDSA have developed special procedures to identify individuals who have already been determined disabled, but are no longer receiving cash benefits from the Social Security Administration, to process referrals in which the Social Security Administration places a medical hold on the disability claim. AHCCCS sends a modified referral packet to DDSA for applicants who have a Federal claim for Social Security benefits pending.

Despite these efforts, the mean processing time for a DDSA determination was 42 days for the period 7/1/96 through 6/30/97, 25 days for the period 7/1/97 through 6/30/98 and 52 days during the last 6 months of 1998. As a result, the ALTCS eligibility determination process typically requires more than 45-days when a disability determination is required.

The excessive time required for eligibility determinations compromises the quality of care available to individuals who are medically institutionalized or at risk of institutionalization and strains the agency's relationships with providers who are expected to provide medical services with no assurance of payment. Although a nursing facility cannot refuse care to a resident, if the individual requires acute care hospitalization, the nursing facility may refuse to re-admit a patient without a means of payment. This

results in unnecessary continued hospitalization and exceptional stress to the patient and family. Individuals who could have been returned to their homes with hospice or other HCBS services have been retained in facilities because they had no payment source for HCBS services while awaiting the DDSA determination.

AHCCCS will implement a 45-day processing time frame for all ALTCS applications if this waiver request is approved, thereby reducing processing time for applications requiring a disability determination and improving customer service.

Summary5SUMMARY

What we have learned from our current waiver verifies that using the PAS to determine disability for children is a reasonable alternative to determining disability using SSI criteria. Additionally, it allows for faster access to services for disabled applicants by simplifying the eligibility process. In our on-going desire to improve services to members by streamlining processes, we request expansion of the current waiver to include all persons applying for ALTCS who are under the age of 65.